STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155277	A. BUILDING 01 B. WING	05/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING PINES HEALTH CARE CENTER	3301 N CALUMET AVE VALPARAISO, IN46383

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/04/11 Facility Number: 000176 Provider Number: 155277 AIM Number: 100288940 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, Whispering Pines Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Whispering Pines desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on June 3, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	This facility located in two, two story buildings was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and spaces open to the corridors. The facility has a capacity of 150 and had a census of 114 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/06/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0054 SS=E	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on observation and	K0054	It is the policy of this facility to	06/03/2011

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	interview, the facility failed to ensure 1 of 1 smoke detectors in the facility's Pines South day room were installed where air flow would not adversely affect its operation. LSC 9.6.1.3 says the provisions of 9.6 cover the basic functions of a complete fire alarm system. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could effect residents in and near the day room smoke detector, including staff and visitors. Findings include: Based on observation with the maintenance supervisor on 05/04/11 at 3:25 p.m., the smoke detectors in the Pines South day room was located within two feet of an air supply duct. This was acknowledged by the maintenance		ensure smoke detectors are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. **I. Specific Corrective Actions:** The Pines South Day room smoke detector was relocated so it is not within two feet of the air supply duct to ensure air flow would not adversely affect the smoke detector's operation. **II. Identification and correction of others:** All smoke detectors were inspected to ensure they were not within two feet of an air supply duct. **III. Systemic Changes:** The NFPA 72, 2-3.5.1 requirements will be reviewed with maintenance staff before June 3, 2011. **IV. Monitoring:** Rounds will be done monthly, for at least six months, to check if any air supply ducts are within two feet of any smoke detector.	

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	supervisor at the time of the observation. 3.19(b)			
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 3 of 3 liquid oxygen storage areas were provided with signage indicating oxygen transferring is occurring. This deficient practice could affect residents, staff and visitors in and near the oxygen storage and transfilling rooms. Findings include:	K0143	It is the policy of this facility to ensure we are following NFPA 99' s and the Compressed Gas Association's standards. **I. Specific Corrective Actions:** Temporary signage was posted and permanent signs ordered to indicate where oxygen transferring is occurring. **II. Identification and correction of others:** There are only three oxygen storage rooms, all three rooms were posted with required signage. **III. Systemic Changes:** The NFPA 99 and	06/03/2011

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	Based on observations with the maintenance supervisor during the tour of the facility between 3:10 p.m. and 3:55 p.m. on 05/04/11, the facility's oxygen storage and transfilling rooms were not provided with a sign indicating transferring of oxygen was occurring. Based on interview at the time of observation, the maintenance supervisor acknowledged the transferring of oxygen does occur in the oxygen storage and transfilling rooms and no sign indicating the transferring of oxygen was occurring in the facility's oxygen storage and transfilling rooms was provided. 3.1-19(b)		Compressed Gas Association requirements will be reviewed with maintenance staff before June 3, 2011. **IV. <u>Monitoring:</u>** The maintenance staff will check monthly, for at least six months, that the signs are in place.	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to	K0144	It is the policy of this facility to ensure generators are inspected weekly and exercised under load for 30 minutes per month in	06/03/2011

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	ensure 2 of 3 emergency generators were equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors in the event of an emergency. Findings include:		accordance with NFPA 99. **I. Specific Corrective Actions:** The generator company was contacted to determine if the two generators without remote manual stops were Level II installations and of a horsepower rating that required a remote shut off device. One of the two generators is a 42.5 horsepower and does not require a remote shut off, the second is a 228 horsepower and a remote shut off will be installed prior to June 3, 2011. **II. Identification and correction of others:** There are only three generators on the property, one already has a remote shut off device, one does not require a remote shut off, and the last will have one installed. **III. Systemic Changes:** The NFPA 110, Standard for Emergency and Standby Power Systems will be reviewed with maintenance staff before June 3, 2011. **IV. Monitoring:** Rounds will be done monthly, for at least six months, to ensure the remote shut offs are in place.	

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	Based on review of the Generator Maintenance records on 05/04/11 at 2:25 p.m. with the maintenance supervisor, there was no documentation available which indicated the horsepower ratings of the generator engines provided. Based on interview with the maintenance supervisor during record review, he stated no remote shut off device existed for generator sets one and three. The maintenance supervisor indicated the generators were installed before 2003. 3.1-19(b)			
K0154 SS=F	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and	K0154	It is the policy of this facility to provide a complete written policy	06/03/2011

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	interview, the facility failed to provide a complete written policy containing procedures to be followed to protect 150 of 150 residents in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. LSC, 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department to be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also to be notified. This deficient practice could affect all occupants in the facility including residents, staff and visitors. Findings include: Based on review of the facility's		regarding procedure to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. **I. Specific Corrective Actions:** The maintenance copy of the Fire Watch Policy was an older policy, the policy was updated in January of 2010 to include the required phone numbers and that the staff must be designated and trained. The maintenance book was updated with the most current policy. **II. Identification and correction of others:** All policy books were checked to make sure they contained the most recent version of our Fire Watch Policy. **III. Systemic Changes:** The current version of our Fire Watch Policy will be reviewed with the management team before June 3, 2011. **IV. Monitoring:** The maintenance supervisor or designee will check monthly to ensure their Fire Watch Policy is the same as the one in Administration and on each floor.	

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	policy and procedure book with the maintenance supervisor on 05/04/11 at 2:15 p.m., the fire watch procedure for an out of service automatic sprinkler system was incomplete. The procedure lacked the telephone numbers for the Indiana State Department of Health (317-233-5359) and the local fire department and it did not include staff must be designated and trained to perform fire watch rounds. The interview with the maintenance supervisor at the time of the record review indicated no other policy or procedure was available to review. 3.1-19(b)			
K0155 SS=F	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8			

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	Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period to protect 150 of 150 residents, in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire	K0155	It is the policy of this facility to provide a complete written policy regarding procedure to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. **I. Specific Corrective Actions:** The maintenance copy of the Fire Watch Policy was an older policy, the policy was updated in January of 2010 to include the required phone numbers and that the staff must be designated and trained. The maintenance book was updated with the most current policy. **II. Identification and correction of others:** All policy books were checked to make sure they contained the most recent version of our Fire Watch Policy. **III. Systemic Changes:** The current version of our Fire Watch Policy will be reviewed with the management team before June 3, 2011. **IV. Monitoring:** The maintenance supervisor or designee will check monthly to ensure their Fire Watch Policy is the same as the one in Administration and on each floor.	06/03/2011

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	alarm system. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the facility's policy and procedure book with the maintenance supervisor on 05/04/11 at 2:15 p.m., the fire watch procedure for an out of service automatic alarm system was not complete. The procedure lacked the required telephone numbers for the Indiana State Department of Health (317-233-5359) and the local fire department and it did not include staff must be designated and trained to perform fire watch rounds. The maintenance supervisor stated at the time of record review, he had no other policy or procedure available to review. 3.1-19(b)			